AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X4) PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  100 BUCHANAN RD  100 NEW TAZEWELL, TN 37825	- WIEIXING	KO FUK MEDICARE	AND HUMAN SERVICES (	154	7123116	FORM	D: 06/21/201
AURIC PROVIDER OR BUPPLIER  LAUREL MANOR HEALTH CARE  SHAMARY STATEMENT OF DEFININGIES (SAM) DEFICIENCY MUST BE PRECEDED BY PLAN (RECHAMAN RO)  PRETEX (RECHAMAN RO)  INTIAL COMMENTS  During the Recertification survey and investigation of complaints #36977 and #37634 conducted on 68/14 through 68/376, at Laurel Manur Health Care, no delicate were olded in relation to complaint #36977. Deficiencies were olded in relation to complaint #36974. Deficiencies were olded in relation to the relation to manufacture in the manufacture in the manufacture in the property were relative to the state nurse side registry or lecens	LOIVICMEN	L 13F DEFICIENCIES	(X1) PROVIDER/SUPPLIED/CLIA			(X3) DA	ITE SURVEY
LAUREL MANOR HEALTH CARE    SUMMARY STATEMENT OF DEFIDIENCIES   DEPOYDER PLAN OF CORRECTION   CALOF DEFICIENCY MUST BE PRECEDED BY FULL   PROPER PLAN OF CORRECTION   CALOF CORRECTION	NAME OF	DROVIDER OF TURNS	445158	B. WING	<u></u>	ne.	://D////
SUMMARY STATEMENT OF DEFIDIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY FULL   RECOULTORY OR LOS DENTRYING IMPORMATION)   PROPEY   RECOULTORY OR LOS DENTRYING IMPORMATION   PROPEY   RECOULTORY OR LOS DENTRYING IMPORTANT   RECOULTORY OR LOS DENTRY	ı						10012016
CAULD DESCRIPTION OF DEFIDIENCES FOR THE PRESENCE OF YOUR				1 1			
During the Recertification survey and investigation of complaints #36977 and #37634 conducted on 6/6/16 through 6/6/16, et Laurel Manor Health Care, no deficiencies were cited in relation to complaint #38977. Deficiencies were cited in relation to complaint #38977. Deficiencies were cited in relation to complaint #38977. Deficiencies were cited in relation to complaint #37634 under 42 CFR PART 483, Requirements for Long Term Care Facilities.  F 226 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guility of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse side registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an amployee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or icensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law firrough established procedures (including to the State survey and carlification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	PREFIX	I ISAUH DEFICIENCY	MINT DE BREARNES EV	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION DATE
Investigation of complaints #36977 and #37634 conducted on 6/8/16 through 6/8/16, at Laurel Marior Health Care, no deficiencies were cited in relation to complaint #36977. Deficiencies were cited in relation to complaint #3697. Deficiencies were cited in relation to complaint #36934 under 42 CFR PART 483, Requirements for Long Term Care Facilities.  F 225  SS=D  All Signification of Part Care Facilities.  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating recidents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an amployee, which would indicate unfitness for service as a nurse aide or other facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of freeldent property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 000	INITIAL COMMENT	rs ·	F 000			<u> </u>
ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or miletreating residents by a court of law; or have had a finding entered into the State nurse side registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an amployee, which would indicate unfitness for service as a nurse side or other facility staff to the State nurse aide registry or ilcensing authorities.  The facility must ensure that all alleged violations involving mistreatment, negledt, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	1	Investigation of com conducted on 6/6/16 Marror Health Care, relation to complain cited in relation to co CFR PART 483, Re- Care Facilities, 483.13(c)(1)(ii)-(iii),	plaints #36977 and #37634  through 6/8/16, at Laurel no deficiencies were cited in t#36977. Deficiencies were pmplaint #37634 under 42 quirements for Long Term	F 225			
Investigation is in progress.  BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X8):DATE		ALLEGATIONS/IND The facility must not been found guilty of mistreating residents had a finding entered registry concerning a of residents or misage and report any knowledger of law against a lindicate unfitness for other facility staff to the facility must ensing authorities. The facility must ensingly mistreatment including injuries of unisappropriation of remmediately to the action other officials in actional misappropriation of remmediately to the action other officials in actional misappropriation of remmediately to the action other officials in actional misappropriation of remmediately to the action other officials in action of the facility must have related and the f	employ individuals who have abusing, neglecting, or by a court of law, or have into the State nurse aide abuse, neglect, mistreatment opropriation of their property; ledge it has of actions by a an amployee, which would service as a nurse aide or he State nurse aide registry as ure that all alleged violations int, neglect, or abuse, inknown source and seident property are reported iministrator of the facility and accordance with State law procedures (including to the lifeation agency).				
(no)sonia	F	revent further potent nvestigation is in pro-	dal abuse while the grees.			1	,
	3ORATORY D	RECTOR'S OR PROVIDER	VSVPPLIER REPRESENTATIVE'S SIGNA				

Any deficiency statement ending with an asteriak (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for rursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program perticipation.

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: 2X1W11

Pacifity ID: TN1302

if continuation sheet Page 1 of 15

TATEMENI	COF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIDI	E CONSTRUCTION		<u>. 0938-03</u> E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		GOW	PLETED
		445158	B. WING		06/	08/2016
NAME OF I	PROVIDER OR SUPPLIES	₹ `	8	TREET ADDRESS, CITY, STATE, ZIP CO	DE	<u> </u>
LAUREL	MANOR HEALTH C	ARE		02 Buchanan RD IEW Tazewell, TN 97025		
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID.	PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETI
TAG	REGULATORY OR	LSG IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE APPROPRIATE	DATE
F 225	Continued From p	age 1	F 225			
	The results of all li	nvestigations must be reported				
1	to the administrate	or his designated				
'	representative and	to other officials in accordance luding to the State survey and	•			j
	certification agenc	y) within 5 working days of the		•		1
	incident, and if the	alleged violation is verified				1
- }	abhiobusta coued	tive action must be taken.	,			İ
						ì
	This REQUIREME	NT is not met as evidenced				
ľ	by:		,	<b>,</b>		1
ļ	B8660 on facility p	policy review, medical record ew, the facility falled to report				
j	and investigate an	allegation of abuse for 1	1			}
	resident (#144) of of 31 residents sar	4 residents reviewed for abuse upled.				
ļ	The findings includ	led:				
	Review of facility p	olicy Abuse [and] Resident				ļ.
	Rights, (no dete) re abuse or prounds (	evealed "Any incident of for suspicion will result in the	] }			<b>)</b>
1	followingAli repoi	rted acis or suspected acis of	1			
1	abuse shall be imn Investigated, le udi	nediately and thoroughly iten investigation report shall	1	•		]
1	be completedexa	imples of abusethreatening a				•
- 1	resident for any rea	asonthe Administrator will				}
	warrantWili Includ	Ident as the situation may le reporting of results to the				
1	proper authorities	.Administrator will report all				
	aneged violetions agencies as recuir	to the state agencyall other edtake all necessary		!		
],	corrective actions,.	k	]			
,	Review of facility p	plicy Abuse Policy, dated				
	3/1/14 revealed "" thorough investigat	The Administrator will direct a	}			1

Robin bloksham

DEPARTMENT OF HEALT	HAND HUMAN SERVICES			PRINTED: FORM	06/21/2016 APPRQVED
CENTERS FOR MEDICAR				OMB NO	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI) A. BUILDIN	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	445156	B. WING,		ORM	08/2016
NAME OF PROVIDER OR BUPPLIER		<del>'                                    </del>	STREET ADDRESS, CITY, STATE, ZIP	CODE	JU/20:10
LAUREL MANOR HEALTH C.	ARE	- 1	902 BUCHANAN RD		
· · · · · · · · · · · · · · · · · · ·			NEW TAZEWELL, TN 37825		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRRFIX TAG	PROVIDER'S PLAN DE C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(XII) COMPLETION DATE
the results of all in agencies as requir lawThe results or reported by the Adstate agency, as re (6) working days of Medical record reviews admitted to the diagnoses including Diabetes Mellitus, Kidney Disease, Disorder, Pain, And Hypertension, and Medical record reviolate Set (MDS) day resident scored 14 for Mental Status (was independent with transfer and the control of the Administration agonothing has been also as a series of the Administration agonothing has been also as a series of the Administration agonothing has been agone and the Administration agonothing has been agone and the Administration agonothing has been agone and the Administration ago	trator is responsible to report vestigations to the state ed by state and federal f all Investigations must be ministrator to the appropriate equired by state law, within five f the alleged violation"  Idew revealed Resident #144 e facility on 4/8/16 with g Muscle Weakness, Type 2 Atrial Fibriliation, Chronic ementia, Major Depressive ementia, Major Depressive emina, Hypothyroidism, Heart Failure.  Idew of the admission Minimum ated 4/15/18 revealed the out of 15 on the Brief Interview BIMS), indicating the resident vith daily decision making, assist of 1 person with red extensive 2 person assist	F 22	1) No other complaints were resident or the family during stay related to care or committed. The resident was dischibled by the resident was dischibled by the resident was dischibled by the resident that were of interviewable. There were not alleged abuse among the 22 interviewed. The administration canters abuse guidelines on Regional Director of Clinical staff members on duty on Julian immediately re-educated on guidelines. A more extensive recognizing and reporting abon June 16 using a PowerPo All staff members will be reduced to work.  3) The administrator will be educed they returned to work.  3) The administrator will repossible when he is made availegations of Abuse, Neglect according to the regulations of possible when he is made availegation.  4) Any allegation of Abuse, Nexploitation will be reported a federal/state guidelines and the will be responsible for assuring complete and through investion complete and reported according to ficials within the frame. The investigation residual in the centers will be included in the centers well be included in the centers well in the reventions if necessarian other interventions if necessarian complete and interventions if necessarian or a service with the continued compliance and in other interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued compliance in the centers of the resident interventions if necessarian continued	the remainder the interest and by the arged to home on inistrator directed 22 residents coming abuse, considered to be preports of residents or reviewed the June 7 with the Operations. All ne 7, 2016 were the abuse the administration of the company of the abuse of the abuse of the abuse of the abuse of the according to the according to the according to the abuse of the abuse of the abuse of the according to the according to the according to the abuse of the according to the accordingly to the according	8/30/16.

FORM CM9-2567(02-99) Previous Versions Obsidele

Event ID: 2X1W11

Facility ID: TN1302

If continuation sheet Page 3 of 15

Robert / Plaker

<u>CENTE</u>	RS FOR MEDICARE	AND HUMAN SERVICES			FORM.	06/21/2016 APPROVED .0938-039:
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE	19865-1989 1 SURVEY PLETED
<u> </u>		445168	B. WING		06//	00/2016
NAME OF	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00170.10
LAUREL	MANOR HEALTH CA		,	02 BUCHANAN RD IEW TAZEWELL, TN  37825		
(X4) ID PREPIX TAG	I (EACH DEFICIENCY	ITEMENT OF DERICIENCIES Y MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE '	(X5) COMPLETION DATE
F 225	3:25 PM, revealed take away Resident interview with the A Services Superviso conference room, corbal abuse two w	CNA#2 denied threatening to the third that the third third the third thir	F 225			
F 242 98≖D	8/7/16 (14 days),	TERMINATION - RIGHT TO	F 242		٠, ا	
	schedules, and hea her interests, asses interect with membe inside and outside t	e right to choose activities, lith care consistent with his or sments, and plans of care; sments, and plans of care; are of the community both he facility; and make choices or her life in the facility that a resident,		1) The Director of Nursing Server met with the CNA staff in the Lighthouse on June 8 to re-eduthem on the rights of the family the resident's to make choices specifically concerning clothing during sleep time and awake time Resident #53 was specifically.	cate and	6/30/16
	by: Based on medical r and interview, the fe choice to have pajer	IT is not met as evidenced record review, observation, acility falled to honor resident ma bottoms put on correctly of 14 residents reviewed.		observed to have her pajama bottoms in the appropriate posit 2) There is potential for any resito not be clothed in the manner they or their family chooses for The nursing staff made a tour o	ident that them.	
	The findings include Medical record revise	ed: ew revealed Resident #53 was		Lighthouse on June 7th to ensu that other residents were not	re .	
}	admitted to the facill on 6/27/15 with diag Schizophrenie, Anxi Depressive Disorde Communication Def	ity on 8/23/10 and readmitted noses including ety Disorder, Major r, and Cognitive		Impacted.		
ļ	Medical record revie	w of the Minimum Date Set				
RM CMB-266	7(02-99) Previous Versions (	Dhaolete Event ID; 2X1W1	i Fac	Ikly ID: TN1902 If continue	tion sheet	Page 4 of

Robert B Polahar

TATEMEN'	í of deficiencies	E.& MEDICAID:SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(VO) MID TIO	LE CONSTRUCTION		0938-036
ND PLAN (	OF CORRECTION	(DENTIFICATION NUMBER:		J	GOM!	SURVEY PLETED
		445158	a, WING		06/0	38/2016
NAME OF	PROVIDÉR ÖR BUPPLIER			ETREET ADDRESS, CITY, STATE, ZIP C		
LAUREL	MANOR HEALTH CA	ARE		902 BUCHANAN RD NEW TAZEWELL, TN 37825		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	/X51
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		(XS) COMPLETIO PATE
F 242	Continued From pe	3ge 4	F 242			
1	Quarterly Review A	\$\$essment dated 5/16/16	<b></b>	3) All staff working in the	l inhthouse	
	revealed Resident	#53's Brief Interview for Mental		and Harbor Side were rea		
	; Status (a test for co	ognitive ability) score was 3, ant was severely cognitively		the resident's right to make	· ·	
	Impaired.	ant tras severely codimition		and self-determination du		
				week of June 6. The resid	lents in the	
	Medical record rev	lew of the Care Plan	1	Lighthouse and Harbor S		
	"Care Plan Confe	ery dated 7/9/15 revealed erence 3:30 PM sister of		monitored each morning t		
	Resident (responsi	ble partyl hereSeveral		to ensure proper sleeping	attire was in	'
	concerns is on other	er sheet#4. PJ'S (palamas)		place.	·	
	not placing her boti	ioms on at night"		4) The monitoring of appr		ĺ
	Observation of Inco	ontinence care on 6/07/16 at		per week for 3 months an		
	5:57 AM, in the res	ident's room, revealed		time per week for an addi		
	Resident #53's paja	ama bottoms were pulled down		months. After that there w		
	opeervation tovosit	s knees. Continued ed the resident was trying to		monthly checks to ensure		
J	pull the palama bot	toms up after the incontinence		compliance. The results of		
Ì	care was provided.			checks will be reviewed d		
	Interview with Corti	fied Nursing Assistant [CNA]		centers' monthly QAPI me		
	#1 on 6/7/16 at 6:11	AM, on the Light House Hall.		additional interventions, if		
	revealed "pants a	re left below the knees so they		The topic of self-determin right to make choices will		
- 1	won't get wel. Most	don't have enough clothes to		in the orientation for all ne		
ļ	ruguiñe menu evetà	time they get wet"		employees in the future.	,	
	Interview with the D	Prector of Nursing (DON) on				 
	6/8/16 at 10:45 AM,	in the DON's office.	1			
l	confirmed the DON	was aware of the resident's to wear pajema bottoms at			1	
[	night. The DON cor	offrmed the facility failed to				
	honor the resident's	right to choose.				
F 279	483.20(d), 483.20(k	()(1) DEVELOP	F 279	1	•	
99-D	COMPŘÉHENSIVĚ	: UAKE PLANS		[		
	A facility must use t	he results of the assessment			l	[
	to develop, review s	and revise the resident's			;	í

Robert & Alchar

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PF	RINTED: FORM/	08/21/2016 APPROVED
		SIMEDICAID SERVICES	_		.0	MB NO.	0298-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE	
 		445166	B. WING			. 06/0	18/2016
NAME OF F	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
1 ALIBEI	MANOR HEALTH CA	ar.		9	02 BUCHANAN RD		
MANIEL	MANY NEAFIR CA	RE		N	IEW TAZEWELL, TN 37825		
(X4) (D	SUMMARY BTA	TEMENT OF DEFICIENCIES	r ID	Ь.	PROVIDER'S PLAN OF CORRECTION	<u> </u>	faret
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 279	Continued From pa	G			1) The care plan for resident #11	2 was	6/30/16
'		_	F 2	279	reviewed and updated to assess	the i	0,30,10
	comprehensive plan	n of care,			potential for falls resulting from the		
	The facility must de-				prescribed medications on June		1
	nien for each recide	velop a comprehensive care ent that includes measurable			2) There is a potential for other	- '	
1	Objectives and time	tables to meet a resident's			residents to have an increase in	rick for	
.	medical, nursing, ar	nd mental and psychosocial			falls while taking antidepressants		
·	needs that are iden	tifled in the comprehensive			anti-anxiety medications on June		
	assesement,	, , , , , , , , , , , , , , , , , , ,			9th.The MDS Coordinators identi		
							•
	The care plan must	describe the services that are			residents taking antipsychotics a		
	to be furnished to a	ttain or maintain the resident's			evaluated them as fall risk. Care	bigus	
	uiðireer historiosbie	physical, mental, and eing as required under			were modified appropriately.		
		ervices that would otherwise			3) The center's care plan team w		•
	be required under 8	483.25 but are not provided	,		review and update as appropriat		
	due to the resident's	s exercise of rights under			document the increased potentia		
	§483.10, including t	he right to refuse treatment			falls in the care plans of resident		
ŀ	under §483.10(b)(4)	)			taking antidepressants or anti-an		
					medications that have been ider	ıtifled	
	This DECLUDERACK	II la ant mat an audd-acad			as being a risk factor.		
	y (lia κεωσικείνείν Σται κεωσικείνειν	T is not met as evidenced	l		4) Resident falls are reviewed du		
		record review and interview,			Clinical Start Up meeting, risk fa		i
\$	the facility falled to a	ipdate a care plan for	ı		are reviewed as well as intervent		
[1	antidepressant and	antianxiety medication usage			prevent recurrence. All resident t	alls	
- 1	for one realdent (#1:	12) of 5 residents reviewed for			are also reviewed during the Cer		
	unnecessary medica	ations of 31 sampled			monthly QAPI meeting and Risk		
	resid <del>e</del> nis,	·			Factors will be reviewed to main		
ľ	SS				continued compliance.		
	The findings include	10:			·		
	Resident #112 was :	admitted to the facility on			-		
		ses Including Muscle					
		er's Disease, Dementia,			į		
		estroesophageal Reflux.					
}	•	, •				ĺ	
	Miedicai record revié	w of physician's orders sted 7/30/15 for Mirtszapine			[.		
		ated 7/30/15 for Minazapine milligrams (mg) every					}
		3	l		<u></u>		

FORM CM5-2607(02-99) Previous Versions Obsolete

Event ID: 2X1W11

Robert Chlohan

Fedilly ID: TN1302

If continuation sheet Page 6 of 15

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	06/21/2016 APPROVED 0888-0881
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/GLIA IDENT/FICATION NUMBER:	ι, ,		LE CONSTRUCTION	(X3) DATE	
		445156	B. WING	ســـــــــــــــــــــــــــــــــــــ		08/0	B/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAUREL	MANOR HEALTH CA	RE		_	002 BUCHANAN RD NEW TAZEWELL, TN 37825		
(X4) ID PREFIX TAĞ	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROP DEPICIENCY)	) 38 C	(X5) COMPLETION DATE
F 279	Medical record revidence the resident was at the resident was at the resident was at Medical record review of the resident review residence the resident risk for falls.  Interview with the M Coordinator on 6/8/office, confirmed the the antidepressant of the medications incommend the medications incommend the facility must enmedication error rate.  This REQUIREMENT by:  Based on medical rand interview, the famedication error rate observed in the admits and other and observed in the admits at the medication error rate observed in the admits at the record record in the admits and interview, the famedication error rate observed in the admits at the record	er dated 2/17/18 for Ativan twice daily as needed.  ew of the facility's Clinical terly dated 10/15/15, revealed risk for falls.  ew of the care plan updated president was at risk for falls, avealed the care plan did not at taking antidepressant or ion, increasing the resident's risk for antianxiety medication or reasing the resident's risk for its		332			
	The findings include	ng in an error rate of 7.40%.					

Robert & Polisher

Event ID: 2X1W11

Facility ID: TN1302

If continuation sheet Page 7 of 15

FORM CM8-2587(02-99) Previous Versions Obscielo

TATEMEN ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO.	E SURVEY PLETED
		446156	B. WING,		ne:	08/2016
VAIME OF	PROVIDER OR BUPPLIE	R .	<u>,T</u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	9012010
AllRFI	MANOR HEALTH O	Abe	1	902 BUCHANAN RD		
	<del>,</del>			NEW TAZEWELL, TN 37825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDERS PLAN OF CO	ORRECTION	///0
PREFIX TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION)	PREFIX		N SHOULD BE	COMPLETIO
			TAG	DEFICIENCY)		CATE
C 000				1) The LPN who was not	ed to commit	2/22/42
F 332	Continued From p		F 3:	32 the medication error by r	ot monitoring	6/30/16
	Medical record re	view revealed Resident #8 was		the blood pressure on re	sidents	<u> </u>
	admitted to the fa	cility on 11/25/15, with		receiving antihypertensiv		
	Chatrictly District	ng Muscle Weakness, Chronic		was observed during the		
	Essential Hyperte	onary Disease, Diabetes, and	]	medication pass on the r		]
	Traddition Libberta	uploti		she worked on June 9th.	ONE STATE STORE	ļ
	Observation of a r	medication pass on 6/7/16 at	t	2) Blood pressures were	obtained on	İ
	j 7:35 AM, revealed	d Licensed Practical Nurse		all residents on blood pre	ODIGINGU ON	
	(LPN) #2 prepare	d medication for Resident #8.		medication. Nursing adm		}
	i Observation reves	i bebulani noitealbem erit bela		reviewed the medical rec		
	Taprolol 25 mg (m	Illigram) and Norveac 10 mc				
	(generic Amlodipli	ne Besylate) (both medications		residents receiving blood	i pressure	
	tevesied the LEM	ves). Continued observation		medications to ensure th		
	without taking the	administered the medications		pressures were recorded		
	·	plood pressure,		medical record and were		
	Medical record rev	/lew of Resident #8's physician	;	prescribed parameters p		1
	recapitulation orde	ors for 6/2016 revealed		medication administration	n on June 8 <sup>th</sup> .	ť
l	Mětoproloi Tartrate	9 25 mg (Toprolol) 1 tablet by		(3) All LPNs and RNs wer	e reeducated	ļ
	mouth twice daily;	hold for eystolic blond pressure		to follow medication adm		
	iess then 110 or he	eart rete less than 55:		parameters for all medica		1
ĺ	Amicaipine Besyle	te 10 mg (Norvasc), 1 tablet by		including antihypertensiv		
	Then 100 or Alectal	or systolic blood pressure less		9tn.	1	1
	man roo or diago	lic blood pressure less than 50.		4) RN nursing supervisor	s will observe	
i	Interview with I PN	I #2 on 6/7/16 at 7:45 AM, in		a weekly med pass for 3	months and a	(
	the hallway, reveal	led the LPN had not taken the		monthly observation by t	ne consultina	
	resident's blood pr	essure because the resident		pharmacist. A monthly of	servation will	
ŀ	had been taking th	e medication long term.		be completed by nursing		
	Continued Intervier	w revealed, due to the resident		administration thereafter.	Any error	
	taking the medicat	ion long term, it was not		noted during observation		
1	required to take the	e blood pressure.		reviewed Immediately with		
- 1	Intendeur with the r	Disaster of the make a series of the		a 1 on 1 present time edu		
- 1	9:40 AM, in the ear	Director of Nursing on 6/7/16 at Inference room, confirmed the		results will be reported to		
[	blood bressum wa	s to be taken prior to				
[	administering hype	rtensive medications.		committee Monthly for 3	เบอมนอย <b>มายม</b>	
F 441	463.65 INFFCTIO	N CONTROL, PREVENT	F 44	on a quarterly basis	,	
		· CONTROL   CEACIAL	F 44	11	•	ſ

Robert & Blaker

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Př	RODMA	06/21/2016 \PPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	_		Of	AB NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/GLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		445156	B. WING	<u> </u>		08/0	8/2016
NAME OF F	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	<del>, , , , ,</del>	
LAUREL	MANOR HEALTH CA				02 BUCHANAN RO NEW TAZEWELL, TN 37825		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPE DEFICIENCY)	RE	COMPLETION (X0)
	Infection Control Presafe, sanitary and of to help prevent the of disease and infection Control The facility must est Program under which (1) investigates, cor in the facility; (2) Decides what preshould be applied to interest the facility (3) Maintains a reconstitutional related to interest (1) When the Infectional delermines that a reprevent the spread cliculate the resident. (2) The facility must communicable disease to help service the spread cliculate the resident.	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.  Program tablish an infection Control on it - mirols, and prevents infections occurres, such as isolation, o an individual resident; and ord of inoldents and corrective fections.	F4	441			
	direct confact will tra (3) The fecility must hands after each dir hand washing is ind professional practica (c) Linens	ansmit the disease, require staff to wash their rect resident contact for which licated by accepted a.		•		1	,
:"	transport linens so a infection.	dle, store, process and is to prevent the spread of	i	·			

FORM CM9-2687(02-99) Previous Versiona Obsolete

Event ID: 2X1W11

Facility ID: TN1302

If continuation sheet Page 9 of 15

Robert & Bleker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING  (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X5) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X8) DATE SURVEY COMPLETED  (X9) DATE SURVEY COMPLETED  (X1) DATE SURVEY COMPLETED  (X2) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X1) DATE SURVEY COMPLETED  (X2) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X5) DATE SURVEY COMPLETED  (X6) DATE SURVEY COMPLETED  (X7) DATE SURVEY COMPLETED  (X8) DATE SURVEY COMPLET	CENTE	<del>RS.FOR MEDICARI</del>	I AND HUMAN SERVICES		•		FORM /	06/21/2016 \PPROVED 0936-0391
NAME OF PROVIDER OR SUPPLIER  LAUREL MANDR HEALTH CARE    XIMANDR HEALTH CARE   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOSITE OF DEFICIENCIES (EACH DEPOSITE OF DEFICIENCY MUST as E PRECEDED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION)   PARETX (EACH DEPOSITE OF THE APPROPRIATE DY THE APPROPRIATE DEPOSITION OF THE APPROPRIATE DY THE APPROPRIATE DY THE APPROPRIATE DEPOSITION OF THE APPROPRIATE DEPOSITION O	I STATEMEN	COR DEFICIPNOIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	BURVEY
This REQUIREMENT is not met as evidenced by: Based on facility procedural guideline rorrigance and service for Fesidents observed in the main ching room.  The findings included:  Review of the facility procedural guideline for "Perinasa Care" dated 2014 revealed "Staff must gather supplies			445156	B, WING	·	<u></u>	nero	19/2014B
SUMAND ATTEMENT OF DEFICIENCIES   DEFICIENCIES   PROVIDERS PLAN OF CORRECTION   PREFIX   REGULATORY OR LISC IDENTIFYING INFORMATION)   PREFIX   REGULATORY OR LISC IDENTIFYING INFORMATION   PREFIX   REGULATORY OR LISC IDENTIFY   REGULATORY OR LISC IDENTIFY   REGULATORY OR LISC IDENTIFY   REGULATORY OR LISC IDENTIFY   PROFIX   REGULATORY OR LISC IDENTIFY   REGULATORY OR	NAME OF	PROVIDER OR SUPPLIER		<u>l:</u>	STREET ADDRESS, CITY,	STATE, ZIP CODE	Vore	0/2018
FREETY (EACH DEFIDIENCY NUIT BE PRECEDED BY UILL TAG (EACH CORRECTIVE ACTION HOLD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFIDIENCY)  F 441  Continued From page 9  This REQUIREMENT is not met as evidenced by: Based on facility procedural guideline review, facility audit tool review, observation, and interview, the facility failed to disinfect hands during medication administration for 1 Resident (#8) of 5 residents observed during medication administration; failed to disinfect hands during incontinence care for 12 residents (#51, #87, #46, #65, #61, #84, #40, #128, #55, #55, #90 and #113) of 12 residents observed for incontinence care; and failed to disinfect hands during meal service for 6 residents observed in the main dining room.  The findings included:  Review of the facility procedural guideline for "Perinaal Care" dated 2014 revealed "Perform hand hygiene. Apply clean glovesDispose of glovesperforms hand hygiene"  Review of Peri Care Audit Tool (no date) revealed "Staff must gather supplieswash hands, Applies/puts on glovesWashes hands before leaving the room"  Review of the facility procedural guideline for "Hend Hygione" dated 2014 revealed "Wash hands with either plain scap and water or anlibsoberial scap and waterBefore and after having direct contact with nanimate objectsmedical equipmentAfter removing gloves"  Review of Hand Hygione Care Audit (no date) revealed "Hand washing is done before and after each resident contactHand washing is	LAUREL	MANOR HEALTH CA	ARE			37825		
This REQUIREMENT is not met as evidenced by: Based on facility procedural guideline review, facility audit tool review, observation, end interview, the facility falled to disinfect hands during medication administration for 1 Resident (#8) of 5 residents observed during medication administration; falled to disinfect hands during incontinence care for 12 residents (#81, #87, #49, #65, #61, #84, #40, #128, #35, #83, #90 and #113) of 12 residents observed for Incontinence care; and falled to disinfect hands during meal service for 6 residents of 23 residents observed in the main dining room.  The findings included: Review of the facility procedural guideline for "Perinaal Care" dated 2014 revealed "Perform hand hyglena. Apply clean glovesDispose of glovesperforms hand hyglene"  Review of Peri Care Audit Tool (no date) revealed "Staff must gather suppliesweak hands. Applies/puts on glovesWashes hands. Applies/puts on glovesWashes hands before leaving the room"  Review of the facility procedural guideline for "Hand Hyglene" dated 2014 revealed "Wash hands with either plain soap and water or antibacterial soap and water or antibacterial soap and waterBefore and after having direct contact with patientsAfter contact with patientsAfter removing gloves"  Review of Hand Hyglene Care Audit (no date) revealed "Hand washing is done before and after each resident contactHand washing is	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECT CROSS-REFEREN	TIVE ACTION SHOULD CED TO THE APPROPE	片	(XB) COMPLETION DATE
revealed "Hand washing is done before and after each resident contactHand washing is	F 441	This REQUIREME by: Based on facility p facility audit tool re interview, the facilit during medication: (#8) of 5 residents administration; falls incontinence care f #66, #61, #64, #40 #113) of 12 resider care; and falled to service for 5 reside in the main dining r The findings includ Review of the facilit "Perineal Care" dat hand hygiens. Appl glovesperforms h Review of Peri Care "Staff must gathe. Applles/puts on glo leaving the room" Review of the facilit "Hand Hygiene" dat hands with either pl antibacterial soap a having direct contar with inanimate obje removing gloves"	NT is not met as evidenced rocedural guideline review, view, observation, and y failed to disinfect hands administration for 1 Resident observed during medication of to disinfect hands during or 12 residents (#51, #87, #49, #128, #35, #53, #90 and its observed for incontinence disinfect hands during meal into of 23 residents observed com.  ed:  ty procedural guideline for sed 2014 revealed "Perform y clean glovesDispose of and hygiene"  a Audit Tool (no date) revealed in supplieswash hands, vesWashes hands before the 2014 revealed "Wash is soap and water or and waterBefore and after out with patientsAfter contact ctsmedical equipmentAfter	, F,			-	
TOTAL CHIC CORRESPONDED TO THE CONTRACT OF THE		revealed "Hand w after each resident	ashing is done before and contactHand washing is	<u> </u>		, i.e.		· · · · · · · · · · · · · · · · · · ·

Facility ID: YN1302

If continuation sheet Page 10 of 15

Robert & Polcher

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PR	INTED; FORM	08/21/2016 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		<u>//Bi.NO.</u> (X3) DATE	.0836-0391 SURVEY PLETED
		448156	B. WING				nazi	<u>0</u> 8/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			DOI ZO 10
LAUREL	. MANOR HEALTH CA				902.BUCHANAN RD NEW TAZEWELL, TN 37B25			
(X4) ID PREFIX TÄG	I (BAGH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULDI	BE	(X6) COMPLETION DATE
	gloves and washes roomWashes han removed"  Observation of a me 8/7/16 at 7:20 AM, r Nurse (LPN) #1 had ungloved hands and medication cup. Cor the LPN handed the resident to swallow revealed the resident off the filt the pill on the medication off the filt the pill on the medication drawer, replaced dropped pill and administered the filt hands prior to retriev the cart, did not disinfected the hands after picking the not disinfected the hands after picking the medication, or hands medication, or hands medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication, or hands after picking the medication of th	remove glovesremoves hands before leaving a ds every time gloves are adication administration on evealed Licensed Practical prepared the medication with placed the medication in a ntinued observation revealed medication cup for the the pills. Observation of the LPN picked the por with bare hands, placed atton cert, had coworker ion of pill, opened the retrieved another pill to ill, returned to the resident a pill. Observation revealed affect the hands after picking cor, did not the disinfect reference in medication from addition medication from addition medication from a fect the hands after picking addition medication from a fect the hands prior to	PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI		ntrol ing neal neal neal neal neal neal neal neal	6/30/16		
	realdent. Observation of Certif the Lighthouse Hallw through 6:07 AM, rev	led Nurse Aide (CNA) #1 on rev on 6/7/16 from 6:11 AM			demonstration. 4) The results of the monitoring process will be reported mont QAPI committee meetings for months and then quarterly the to monitor for continued comp	nly e 2 reaf	fter	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 2X1W11

Facility ID: TN1902

If continuation sheet Page 11 of 15

Robert BPolcher

		AND HUMAN SERVICES  SIMEDICAID SERVICES				FORM	: 08/21/2018   APPROVED   0938-0991
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/GLIA IDENTIFICATION NUMBER:			PLE GONSTRUCTION B	(X3) DA	ČE SURVEY MPLETED
		445156	B, WING	3 <u> </u>		06	/08/2016
	PROVIDER OR SUPPLIER MANOR HEALTH CA	RE	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUCHANAN RD NEW TAZEWELL, TN 37825	<u> </u>	
(X4) ID PREFIX TAG	(EACH DÉFICIÉNC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PAEF TAC	×ΙΣ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	COMPLETION DATE
F 441	CNA#1 provided in #51 wearing gloves revealed CNA#1 reproviding care, did proceeded to anoth Resident #87 (room CNA#1 donned globrief and sheets, rewash the hands, as resident's room.  Resident #49 (room CNA#1 donned globrief and exited the resident wand exited the resident wand exited the resident #55 (room CNA#1 donned globrief, removed the another resident's Resident #61 (room CNA#1 donned globrief, removed the hands, and proceed room.  Resident #64 (room CNA#1 donned globrief, removed the hands, and proceed room.	accontinence care for resident and Continued observation amoved the gloves after not wash the hands, and ner resident's room.  In 113A) at 5:15 AM - Observed oves, changed the resident's amoved the gloves, did not not proceeded to another and proceeded to another oves, checked the resident for aching linens under the vas dry), removed the gloves, dent's room without washing an 116A) at 5:29 AM - Observed oves, changed the resident'e gloves, did not wash the hands gloves, and proceeded to		44			

FORM CM6-2567(02-99) Previous Versions Obsolete

Event ID: 2X1W11

Facility ID: TN1302

if continuation sheet Page 12 of 15

Robert BAlchan

		AND HUMAN SERVICES & MEDIÇAID SERVICES				FORM	06/21/2016 APPROVED 9.938-9391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COM	(X3) DATE BURVEY COMPLETED			
445188			e. WING	3_		06/0	06/08/2016			
NAME OF F	ROVIDER OR SUPPLIER			Γ	SYREET ADDRESS, CITY, STATE, ZIP CODE					
LAUREL MANOR HEALTH CARE				902 BUCHANAN RD NEW TAZEWELL, YN 37825						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUSY BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAC	FΙΧ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND TO THE APPROPRIEM OF THE APPROPRIEMCY)	JLD 8E	(X6) COMPLETION DATE			
F 441	pajama bottome do the resident's brief observation revealed gloves, did not was another resident's in Resident #128 (roo CNA #1 donned gloves) for incontinent resident was dry.) revealed CNA #1 rewash the hands, as resident's room.  Resident #35 (roon CNA #1 donned gloves) did not was resident's room.  Resident #53 (roon CNA #1 donned gloves) did not was a resident for incontinence. Cwash her hands be #4 and CNA #1 doresident for incontinence. Cwash her hands be #4 and CNA #1 doresident for incontinence. Cwash her hands be #4 and CNA #1 doresident for incontinence. Cwash her hands be #4 and CNA #1 doresident for incontinence. Cwash her hands be #4 and CNA #1 doresident for incontinence care, and proceeders.	and sheets. Continued and sheets. Continued and sheets. Continued and sheets. Continued and sheets. Continued and sheets. Continued the high the hands, and proceeded to room.  In 119) at 5:44 AM - Observed oves, checked the resident's be with gloved hands (the Continued observation amoved the gloves, did not and proceeded to another.  In 110A) at 5:48 AM - Observed oves, changed the resident's amoved the gloves, did not and proceeded to another.  In 105B) at 5:57 AM - Observed A #4 with checking the resident continued gloves, and checked the mence. CNA #1 removed the shift hands after providing and to another resident's room.  In 101A) at 5:55 AM - Observed a resident's room, and without, touched the resident several Continued observation id not wash the hands after		44	11					
•	Observed CNA#1	om 101B) at 6:07 AM - donned gloves, changed the noved the gloves, and did not								

FORM CM8-2567(02-99) Previous Versions Obsolets

Event ID: 2X1W11

Facility ID: TN1302

If continuation sheet Page 13 of 16

Robert & Bloker

DEPARTMENT OF HEALTH AND HUMAN SERVICES  FORM APPROVED.									
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB: NO. 0088-0383									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
445188		8. W)NG	عندا		06/08/2016				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP GODE						
LAUREL MANOR HEALTH CARE				902 BUCHANAN RD NEW TAZEWELL, TN 37826					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX [EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE		
F 441	Continued From page 13 wash the hands before exiting the resident's room.  Interview with CNA #1 on 6/7/16 at 6:11 AM, on the Lighthouse Hallway, confirmed she had not washed her hands after removing the gloves.		F	<del>14</del> 1					
	Interview with the Director of Nursing (DON) on 16/8/16 at 10:36 AM, in the DON's office, confirmed the facility's staff was expected to wash their hands before donning gloves and after removing the gloves. Continued interview confirmed the facility had failed to follow their infection control policies for hand hygiene to prevent the spread of infection:					1			
	on 6/6/16 at 11:46 A Therapist #1 moved chair closer to teble resident's ball cap of touched her face ar female resident in w clean glass from cle female resident, rob her hair, walked to d eliverware and gave exited dining room a	main dining room meal service.  M, revealed Speech I a male resident in wheel I, touched another male In his head, continuously I be played with her hair, moved I her i chair to table, retrieved a I am cart end gave to a another I bed her nose and played with I clean cart retrieved clean I to a different resident, than I and went into the Therapy I but washing her hands.				•			
	12:07 PM, outside to confirmed she had a	ch Therapist #1 on 6/6/16 at he main dining room, not sanitized the hands after a residents and wheel chairs,	,						
· [1	the DON's office, co #1 should have was	ON on 6/8/16 at 10:36 AM, In infirmed the Speech Therapist had her hands in between meal service. Continued							

FORM CMB-2587(02-99) Previous Versione Obsolele

Event ID: 2X1W11

Facility ID: TN1302

If continuation sheet Page 14 of 15

Robert & Polahar

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/21/2016 APPROVED 0938-0591			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	(X3) DATE SURVEY COMPLETED			
	44515B			·	,	06/08/2016				
NAME OF	NAME OF PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CO	DE				
LAUREL MANOR HEALTH CARE				NEW TAZEWELL, TN 37826						
(X4) ID PREFIX TAG	(EACH DEFICIENCS	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREF TAG	IX	PROVIDER À PLAN OF COR ACH CORRECTIVE ACTION : SS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X8) COMPLETION DATE			
F 441	Continued From ps interview confirmed hands during the m	the facility failed to sanitize	F	441						
; ;		•								
<b>.</b>										
,										
•										
							1			
PORM CMS-26	87(02-99) Previous Versions	Obeolele Even( ID: 2X1)	V11	Facility ID: TN	11302 If	continuation sheet	Page 15 of 15			

Robert BRolchan